Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012607	A. BUILDING _____ B. WING _____	02/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN LEHMAN ENDOSCOPY SUITE	550 N UNIVERSITY BLVE, SUITE 4100 INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a pre-occupancy survey. Facility Number: 012607 Survey Date: 2-15-12 Surveyor: Jack I. Cohen, MHA Medical Surveyor Glen Lehman Endoscopy Suite meets the requirements for Ambulatory Surgery Center Licensure Rules 410 IAC 15-2 to admit and treat patients. QA: claughlin 02/17/12	S 000		